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The Role of School-Based Health Centers under Universal Coverage for Children and Youth in California: Issues and Options

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Student Access to Health Care Services

Executive Summary

Background

Currently, more than 8 million children across the United States lack health coverage. In 2005, there were 1.1 million uninsured children in California alone. In a wide-sweeping proposal aimed at closing the gaps in access to health care for all Californians, Governor Arnold Schwarzenegger is promoting systemic reform through his health care proposal that envisions "…an accessible, efficient, affordable health care system that promotes a healthier California through prevention and wellness and universality of coverage." Additionally, Governor Schwarzenegger announced a plan in August 2006 to expand by 500 the number of school-based health clinics in California elementary schools "to jumpstart…efforts to reform health care delivery." Concurrently, proposals have been coming forth from the legislature further defining universal coverage for all children in the state. The Governor's proposals, coupled with these legislative initiatives, present an unprecedented challenge to Golden State policymakers to develop an innovative system to deliver health care services to children and youth. Such a system will have to be financially viable, accessible to all, medically efficient, culturally competent, collaborative between public and private sectors, and coordinated and monitored for accountability. It is important to lay a common foundation for this new model of school-based health centers now, so that various constituent groups— from industry to insurers to medical practitioners and educators—may begin to construct their framework of resources and services upon it.

Purpose and Methodology

This paper presents issues and options for a new model of health care delivery to all children and youth in California under universal care. In particular, it addresses the role of schools and school-based health centers (SBHCs) and their many public and private partners as they work to secure the physical, mental and emotional health of children and youth. This report is meant to stimulate and focus additional discussion and research, not to present a full-blown model ready for implementation. It is meant to challenge and inform policymakers to clearly think through the goals and role of SBHCs under universal coverage.

Using national lessons learned as a starting point for discussion, we facilitated a series of meetings with stakeholders on some of the issues and options that may shape a new model for California. Together with The California Endowment, we convened stakeholders to address five primary topic areas: the status and future of school-based health centers; child and youth mental health issues; health care needs specific to special needs children and youth; health plans and programs; and health care providers who work with children and youth. Information gleaned from these interviews and group sessions, coupled with research and data on best practices and the status of health care systems as they serve children and youth, fed the development of recommendations for a new model to deliver care in California schools. Our process was participatory, but did not aim to achieve consensus among the participants.

School-Based Health Centers in California

There are more than 4 million low-income children receiving state-sponsored health coverage today in California. Approximately 750,000 additional children who are currently uninsured would receive coverage under Governor Schwarzenegger's health care reform proposal including all of the uninsured children below 300% FPL, regardless of residency status. The Governor believes that schools should be a point where families can link to health care information and, where feasible, health care services. He signed AB 2560 (Ridley-Thomas 2006) in September 2006, which created the Public School Health Center Support Program to strengthen collaborative efforts between the California Department of Education (CDE) and the Department of Health Services (DHS) to improve the health and educational readiness of children. His support derives in part from the fact that there are approximately 150 SBHCs operating in California today that address local needs for health care in both urban and rural settings. These centers tend to serve low-income children and youth from different cultures, who speak languages other than English, and who often have relied upon emergency rooms rather than primary care providers for care. As there are no dedicated funding streams for SBHCs from California State or Federal coffers, they tend to rely upon local grants and third-party billing to finance the services they provide including prevention, primary care and mental health. Many also provide a number of services that do not qualify for reimbursement such as outreach and enrollment, case management, health education and referrals to services that they do not or cannot provide. The result is that SBHCs often provide a medley of grant-specific and reimbursement-proscribed services according to the competing and combined interests of funding sources. Most have become interstitial providers, filling the gaps in access and coverage for low-income children, youth and their families.

Given the wide variation among SBHCs in the scope of services provided, populations served, access to coverage and sponsorship type, and the lack of regulating policy, it can be safely stated that there is not one standard, scalable model to reach the 94 percent of schools districts that do not provide access to health care for their students through SBHCs today.

A New Option

Lessons learned from other states can be applied to California as a new model of service delivery is developed. In "School Health Centers in California: Building on the Past; Learning from Experience," Julia Graham Lear reviews the history of SBHCs nationwide and in California. She concludes that there are three basic options for the Golden State to follow when thinking about the future of SBHCs: 1) no state action, 2) a state grant program and 3) a school-based health access program. After listening to stakeholders in five roundtable sessions, we believe that schools can play a more active role in providing access to health care to students. For a viable strategy, we recommend that the state develop and fund a program to expand access to health care in every school district based on the third option above, the school-based health access program.

We submit that schools could facilitate access to health care in a similar way under reform that provides universal coverage. Since all students would have coverage, a school-based

health access program in every school district could:

- Serve as an information hub to provide access to health and enrollment information for all students;
- Provide the following set of minimum services: facilitate enrollment in health care plans, provide health prevention information, provide preventive dental health care at the elementary level, and preventive mental and behavioral health services at the middle and high school levels;
- Deliver these services to all students and their families during standard working hours at district sites; and
- Provide services in ways that are culturally competent for the community being served, and specific to the local health care environment.

The School-Based Health Access Program (SBHAP) that we propose as an option for California policymakers to consider would be useful, affordable and implementable under universal coverage; it will be scalable, equitable and adaptable to the variety of schools and communities across the state; it would have an electronic backbone that would facilitate the flow of health information and data, and enable enrollment in health plans; and it would provide incentives for districts to deliver preventive dental and mental health services. Every school district would be required to provide a set of baseline services, but could also elect to augment those services with local resources to provide anything from more wellness information to full primary care services and beyond, just as 146 SBHCs across the state are doing now.

The guiding philosophy behind this model is that under universal care, all children and youth will have health coverage, and that the role of the SBHAP would be to facilitate access to health information and care from a location that is convenient, known, and family-friendly. Each school district would be required to implement an SBHAP with minimum services, and encouraged to provide additional health care services according to community interest, needs, and local resources available.

The SBHAP model does not presume to impede or preclude a school district's impetus to expand health care services, but rather to create a basic set of services available to all schools and all students in California regardless of location or ability to pay in order to increase access to health care under universal coverage.

The funding for a School-Based Health Access Program would come primarily from the same sources of funds that SBHCs access today: state health insurance programs, third-party payers, and local grants. Our proposal recommends consideration of the following three significant changes to the way funding would be delivered:

1. The state would pay for the development and implementation of the electronic database required for all school districts and assures the availability of the infrastructure to allow for outreach and enrollment to take place within schools.
2. The state would create a Denti-Cal or Medi-Cal carve-out for school districts to provide preventive oral health care to elementary school students.

3. The state would create a Medi-Cal carve-out for school districts to provide preventive mental and behavioral health education to middle and high school students.

Summary Remarks and Next Steps

We believe that policymakers should be focused on assuring that every school district works with local public health systems, and public and private insurers to develop plans for community-specific health care delivery that makes use of schools as hubs for information, outreach, and enrollment in health plans, and to provide access to basic wellness education and some preventive services. Additional health care services should be available at schools or through school-linked services according to the specific needs of the local population and the resources available in or generated by the community through stakeholder groups. Separate state funding for a school-based health center grant program may meet the needs of some communities. Without readily available access to health information and basic preventive services in all schools, there will be little or no change to the status quo in most communities and for most Californian children and youth. A school-based health access program will assure that universal coverage achieves its purpose of increasing widespread access to health care services for all children and youth.

This project was designed to present issues and options for further study. If some of these issues and options resonate with policymakers, we would recommend the following topics for further investigation:

1. The exploration and definition of issues involved in implementing a School-Based Health Access Program model;
2. The potential integration and alignment of the School-Based Health Access Program model with current and pending legislation in these and other areas: oral health screening, treatment and education; school health centers; the Mental Health Services Act; and outreach and enrollment; and
3. The exploration of whether there is an opportunity to reframe the ways that services are delivered to children and youth with special needs under the scenario of universal coverage.

I. Introduction

A. Health Care Reform: Children and Youth in California

Currently, more than 8 million children across the United States are not insured for health care. In 2005, there were 1.1 million uninsured children in California alone.[1] In a wide-sweeping proposal aimed at closing the gaps in access to health care for all Californians, Governor Arnold Schwarzenegger is promoting systemic reform through his health care proposal that envisions "…an accessible, efficient, affordable health care system that promotes a healthier California through prevention and wellness and universality of coverage."[2]

[1] 2005 California Health Interview Survey. UCLA Center for Health Policy Research, March 2007. Available at www.healthpolicy.ucla.edu. Accessed 5/27/2007.

[2] Office of the Governor, State of California. Governor's Health Care Proposal. Page 1. Available on the web at http://gov.ca.gov/pdf/press/Governors_HC_Proposal.pdf. Accessed 8/2/2007.

Additionally, Governor Schwarzenegger announced a plan in August 2006 to expand by 500 the number of school-based health clinics in California elementary schools "to jumpstart…efforts to reform health care delivery."[3] Concurrently, proposals have been coming forth from the legislature further defining universal coverage for all children in the state. The Governor's proposals, coupled with these legislative initiatives, present an unprecedented challenge to Golden State policymakers to develop an innovative system to deliver health care services to children and youth. Such a system will have to be financially viable, accessible to all, medically efficient, culturally competent, collaborative between public and private sectors, and coordinated and monitored for accountability. It is important to lay a common foundation for this new model of school-based health centers now, so that various constituent groups— from industry to insurers to medical practitioners and educators—may begin to construct their framework of resources and services upon it.

B. Objectives

This paper presents issues and options to The California Endowment and policymakers for a new model of health care delivery to all children and youth in California under universal care. In particular, it addresses the role of schools and school-based health centers (SBHCs) and their many public and private partners across the state as they work to secure the physical, mental and emotional health of children and youth. It is meant to challenge and inform policymakers to clearly think through the goals and role of SBHCs under universal coverage for children and youth. It is not intended to present a full-blown model ready for implementation. Rather, the issues and options presented herein are meant to stimulate and focus additional discussion and research, especially regarding implementation of a new model.

C. Methodology

Using national lessons learned as a starting point for discussion, we facilitated a series of meetings with stakeholders on the issues and options that will generate a new model for California. Together with The California Endowment, we convened and engaged stakeholders from across the state in roundtable discussions addressing five primary topic areas: the status and future of school-based health centers; child and youth mental health issues; health care needs specific to special needs children and youth; health plans and programs; and health care providers who work with children and youth. Information gleaned from these interviews and group sessions, coupled with research and data on best practices and the status of health care systems as they serve children and youth, fed the development of recommendations for a new model to deliver care in California schools. Our process was participatory, but did not aim to achieve consensus among the participants. Roundtable participants do not necessarily endorse the options and model presented herein.

[3] Office of the Governor, State of California. Press release: Governor Schwarzenegger Convenes Summit on Health Care Affordability, July 24, 2006. Available on the web at http://gov.ca.gov/index.php/press-release/2570/. Accessed 5/27/2007.

[4] This paper will use the term School-Based Health Centers (SBHCs) as a general descriptor for "school health centers", "school-based health clinics", and "school-linked clinics". The term refers to an entity located on a school campus that provides organized access to medical and mental health services, on- or off-site.

D. Acknowledgements

We would like to thank The California Endowment for its ongoing work at the policy and at the grassroots level to improve the health of underserved individuals and families by expanding access to health and mental health services across the state. The California Endowment provided invaluable logistical support to this project without which we could not have "listened to" such a wide range of representative stakeholders. Serena Clayton and her staff at the California School Health Center Association (CSHC) assisted us in understanding the current landscape of SBHCs across the state, and connected us with many CSHC members who participated in the roundtables. We also would like to acknowledge the invitation from the California HealthCare Foundation, and consultants Bobbie Wunsch and Catherine Teare that allowed us to observe the proceedings of the Governor's Advisory Workgroup on School-Based Health Care. The Workgroup was engaged to examine issues similar to those under our lens, and we found the meetings informative and useful.

II. Universal Coverage

There are more than 4 million low-income children receiving state-sponsored health coverage today in California.[5] Approximately 750,000 additional children who are currently uninsured would receive coverage under Governor Schwarzenegger's health care reform proposal including all of the uninsured children below 300% FPL, regardless of residency status. It is estimated that 220,000 children below 100% FPL would be enrolled in Medi-Cal, and 250,000 more children between 101% and 300% FPL would be enrolled in Healthy Families. Of the remaining uninsured children, approximately 210,000 will be enrolled in employer-sponsored coverage and 50,000 would be covered by private insurance purchased by their parents or guardians (the Governor's proposal would mandate that all Californians either be enrolled in state or employer-sponsored programs, or purchase private insurance).[6] A substantial portion of these children may be undocumented and may live in the Central Valley.

Governor Schwarzenegger believes that schools should be a point where families can link to health care information and, where feasible, health care services. He signed AB 2560 (Ridley-Thomas 2006) in September 2006, which created the Public School Health Center Support Program to strengthen collaborative efforts between the California Department of Education (CDE) and the Department of Health Services (DHS) to improve the health and educational readiness of children. It would provide state level leadership for the development and oversight of school-based health centers, including outreach and enrollment in state-sponsored health care programs.[7] Although the bill was passed without funding, it has influenced additional pending legislative proposals that

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[5] Office of the Governor, State of California. White Paper: School-Based Health Centers. Page 3. Available on the web at http://gov.ca.gov/images/page/health/SchoolBasedHealthCenters.pdf Accessed 8/2/2007.

[6] Governor's Health Care Proposal, P. 1. Available on the web at http://gov.ca.gov/pdf/press/Governors_HC_Proposal.pdf . Accessed 8/2/2007.

[7] To see the full text of AB 2560, go to http://www.leginfo.ca.gov/pub/05-06/bill/asm/ab_2551-2600/ab_2560_bill_20060919_chaptered.html For an overview of AB 2560, go to http://www.schoolhealthcenters.org/policy.asp

would not only fund the program but also provide grants to establish new SBHCs across the state.

This confluence of proposals in the legislature could have a powerful effect on health care coverage and services for children and youth in California. It also provides a unique opportunity for California to consider building systems to ensure that expanded coverage for children and youth translates into increased and efficient access to services.

III. School-Based Health Centers in California

School-based health centers first appeared in California in the 1980s when they began to provide primary care services to students from low-income families. Over the next twenty years, they developed across the state to meet local interests and needs for health care in both urban and rural settings. SBHCs have grown without universal standards or general regulation, and with a great deal of local variation. Generally speaking, these centers serve low-income children and youth from different cultures, who speak languages other than English, and who often have relied upon emergency rooms rather than primary care providers for care. They provide services across a wide spectrum including preventive health education, to oral health services, primary care and mental health group counseling. They have been established by grassroots community initiatives as well as by county mental health departments and others. As there are no dedicated funding streams for SBHCs from California State or Federal coffers, local grants and third-party billing have tended to be their financing mechanisms.[8] The result is that SBHCs often provide a medley of grant-specific and reimbursement-proscribed services according to the competing and combined interests of funding sources. Most have become interstitial providers, filling the gaps in access and coverage for low-income children, youth and their families.[9]

Over time, four important areas of variability have come to characterize SBHCs in California:

a) scope of services provided;
b) populations served;
c) access to coverage; and
d) sponsorship type.

Each contributes in greater or lesser degrees to determine how, when and where individual SBHCs function.

a) Scope of Services Provided

There is no common set of services provided by each and every SBHC in California. Just as local health care systems vary in response to provider supply, public health services, health coverage and state law, each SBHC provides its own particular range of services in response to the needs of students and their families. Although California's earliest centers had a focus on preventive health education and services, some centers today have expanded their scope to include

[8] California is one of only nine states nationally that does not specifically allocate state funds to support SBHCS. Office of the Governor, State of California. White Paper: School-Based Health Centers. Available on the web at http:\\www.stayhealthycalifornia.org. Accessed 8/2/2007.

[9] For a more thorough discussion of the history of SBHCs in California, please see Julia Graham Lear: School Health Centers in California: Building on the Past; Learning from Experience, commissioned by the California HealthCare Foundation. June 2007.

behavioral and dental health care as well. Others provide a more focused set of services such as outreach and enrollment, or health education and disease prevention programs. With no standard model for an SBHC in California, they serve their communities in unique ways that fill the interstices between insurance programs, health care providers and facilities, addressing the local barriers to health care services.

According to statistics provided by the California School Health Centers Association, 86 percent of SBHCs in California provide primary medical care, 47 percent provide mental health services, 40 percent provide reproductive health services, and 18 percent provide oral health services.[10]

b) Populations Served

In addition to providing a mix of services, California's SBHCs serve a mix of children and youth and, in some cases, their families. Some SBHCs serve every student who presents for services while others serve defined groups such as those identified by public insurance program eligibility or enrollment, or grant-targeted populations. As described above, SBHCs in California have grown in number over the past twenty years; there are 146 school-based health centers scattered across the state today.[11]

These centers have a wide geographic distribution and can be found in 19 of the state's 58 counties, with concentrations in Los Angeles and the San Francisco Bay Area. This geographic spread indicates a wide variation of culture, language and health concerns among the students served by SBHCs.

Of the 146 SBHCs in California, 119 are located on school campuses with the remaining centers providing services through mobile vans or off-site but school-linked health care facilities. SBHCs operating on school sites are located in 51 out of 5,661 elementary schools (1%), 15 out of 1,267 middle schools (1%), and 46 out of 1,165 high schools (4%). In all, it is estimated that 700 schools receive services from the 146 SBHCs in the state. Approximately 262,000 out of California's 6,312,103 public school students (4%) were served by SBHCs in 2005-06 in 58 out of 1,000 school districts (6%).[12] Out of those 58 districts, 39 have only one SBHC. In contrast, Los Angeles Unified School District has the most SBHCs (38; 26%), followed by San Francisco Unified School District (12; (8%). Even though California has the second most SBHCs in the country after New York State, coverage is still only one center per 46,011 students.[13]

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[10] California School Health Centers Association: "About School Health Centers in California." Available on the web at http://www.schoolhealthcenters.org/about_sbhcs.asp Accessed 7/25/2007.

[11] The data count of numbers of SBHCs in CA varies between 143 and 147 depending on the source. Variation also occurs when identifying the number of SBHCs that serve elementary, middle and high schools depending on how one defines those levels.

[12] Education Data Partnership. *State of California Education Profile: Fiscal Year 2005-06.* Available on the web at www.schoolhealthcenters.org and http://www.eddata.k12.ca.us/Navigation/fsTwoPanel.asp?bottom=%2Fprofile%2Easp%3Flevel%3D04%26reportNumber%3D16 Accessed on 8/2/2007.

[13] Lear, Julia Graham. *"School Health Centers in California: Building on the Past; Learning from Experience",* commissioned by the California HealthCare Foundation. June 2007.

Despite the variation among the populations served by SBHCs, the majority of students who access their services have one common descriptor: they come from low-income families. Overall, 21 percent of the children in school districts that are served by SBHCs live at or below the Federal Poverty Level compared to 15 percent of those in school districts without SBHCs.[14]

c) Access to Coverage

School-based health centers seek access to insurance coverage for the services they provide to students. Since California does not allocate state funds for SBHCs, third-party reimbursements are an important source of their funding. The majority of third-party reimbursements to SBHCs come from the Children's Health and Disability Prevention Program (CHDP), Medi-Cal, the Early Periodic Screening, Diagnosis and Treatment Program (EPSDT), Healthy Families, and Family PACT (Planning, Access, Care, and Treatment). These programs offer different benefits and have different eligibility criteria that present administrative challenges but also can result in changes to the services that each student can access at an SBHC at any given time.

A complicating factor that affects the ability of SBHCs to access coverage for their services is that they generally rely upon a mosaic of incomplete data sources on the insurance coverage and medical home (or lack thereof) for the children they serve. Many children move from school to school and district to district without carrying their education and health records with them, or do not reveal current coverage for any number of personal, economic, or political reasons. Oftentimes, when SBHCs attempt to serve them, students and their families must begin the eligibility determination and enrollment process for coverage anew.

Many SBHCs do not qualify as primary care providers and therefore cannot bill Medi-Cal managed care or Healthy Families plans directly. Some SBHCs struggle to find the time and financial resources necessary to navigate billing systems and successfully seek reimbursement from insurance programs. Many provide a number of services that do not qualify for reimbursement such as outreach and enrollment, case management, health education and referrals to services that they do not or cannot provide.

As described above, SBHCs provide various mixes of services to their targeted populations. These matrices of services are determined by local needs, resources and culture, and, in large measure, by the contracts that the SBHCs and/or school districts have with health clinics and/or hospitals to provide services that are reimbursable by public and private insurance programs. The type of insurance coverage that an SBHC can access for its student clients greatly affects the nature and type of services that it can offer to individual students as well as to the general school population.

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14 California School Health Centers Association: "About School Health Centers in California." Available on the web at http://www.schoolhealthcenters.org/about_sbhcs.asp Accessed 7/25/2007.

d) Sponsorship Type

A fourth factor that affects the nature and delivery of services by an SBHC is its sponsoring organization. The sponsor as legal entity determines staffing patterns, contractual relationships with public and private insurers and other funding sources, operating hours, facilities, and many other defining characteristics of an SBHC.

In California, SBHCs are sponsored by:

- School Districts (46)
- FQHCs (37)
- Non-profit Organizations (18)
- Hospitals and Medical Centers (18)
- County Health Departments (6)
- Mental Health Agencies (3)
- Physicians Groups (3)
- Non-FQHC Community Health Clinics (2)
- Individual Schools (2)
- University/Research (1)
- Others (14)

The diversity of sponsors and sponsor types adds to the complexity of the profile of SBHCs in California. School-based health centers have continued to multiply and serve increasing numbers of children and youth precisely because they are so responsive to local health care systems and conditions. But they also struggle, in many instances, to take full advantage of insurance funding streams and programs that are difficult for such individualized entities to navigate.

Given the wide variation in these four areas, and the lack of regulating policy, it can be safely stated that there is not one standard, scalable model for an SBHC in California today. Additionally, if we flip the statistics cited above, we find that 94 percent of California school districts do *not* provide access to health care for their students through SBHCs today. Even if universal coverage becomes a reality in California, and the School Health Centers Expansion Act (SB 564 Ridley-Thomas)[15] is funded to open new SBHCs, a "standard version" SBHC that is ready for replication in all school districts does not exist.

IV. Lessons Learned from Other States

Lessons learned from other states can be applied to California as a new model of service delivery is developed. In *"School Health Centers in California: Building on the Past; Learning from Experience",* Julia Graham Lear reviews the history of SBHCs nationwide and in California. She concludes that there are three basic options for the Golden State to follow when thinking about the future of SBHCs: 1) no state action, 2) a state grant program and 3) a school-based health access program.[16]

1. No State Action: This option presupposes that no action will be taken by the state Legislature or the Governor's office on health reform regarding the role of schools and school-based health centers. Under such a scenario, the number of SBHCs would grow incrementally, and centers would remain locally driven entities primarily providing medical services to the neediest children. Funding mechanisms would not change, leaving centers to rely upon third-party reimbursement and local grants. SBHCs

[15] SB 564 School Health Centers Expansion Act. For the full text of the bill as amended on July 10, 2007, see http://www.leginfo.ca.gov/pub/07-08/bill/sen/sb_0551-0600/sb_564_bill_20070710_amended_asm_v94.pdf

[16] Lear, Page 17.

would probably not have a significant statewide impact on child health outcomes under this scenario.

If universal coverage were passed without reference to SBHCs, additional funding would be available for services for more children and youth, and may motivate interest on the part of local partners and providers to develop new and/or support existing SBHCs.

2. State Grant Program: California could follow the lead of other states by launching a grant initiative to develop new SBHCs. Such an initiative would define priorities, service objectives and operating standards for SBHCs, and would require significant state leadership. It would require an allocation of new dollars, and would greatly enlarge the safety net for children.

Governor Schwarzenegger has expressed interest in exploring the use of schools and SBHCs to extend the health safety net for children, and, in May 2007, his office established a Governor's Advisory Workgroup on School-Based Health Centers. Its charge was "…to develop recommendations for the expansion of elementary SBHCs in California, in the context of health care reform and its three main goals: prevention, health promotion and wellness; coverage for all California children; and affordability and cost containment."[17] The recommendations of the Advisory Workgroup support the pending Ridley-Thomas Senate Bill 564 to expand the number of SBHCs across California, and begin to outline the priorities, service objectives and standards that SBHCs would follow in order to receive state grants.

Due to funding restrictions, the proposed grants would only be available to a limited number of schools. (The Governor has expressed an intention to fund approximately 500 of the 5,660 elementary schools (9%), and no middle or high schools.[18]) The children in schools with grants would benefit from the new resources to be sure, but if this were the only action taken regarding the use of schools to increase access to health care, there would be little or no change to the status quo in most school districts and for most of California's children and youth.

3. School-Based Health Access Program: California could look to establish a "health access program" in every school district. This program would provide outreach and enrollment in health plans universally, and, in an environment of universal coverage, facilitate the access for all children and youth to care. This approach would not preclude school districts from developing and supporting SBHCs with local leadership and funding. Nor would it prohibit or conflict with the proposed School Health Center Expansion Act.

Lear concludes her report on a positive note, "It is a new day in California, with the Governor,

[17] Governor's Advisory Workgroup on School-Based Health Centers: Executive Summary and Full Report and Recommendations. Page ii. Prepared by Bobbie Wunsch and Catherine Teare. July 2007.

[18] Office of the Governor, State of California. Press release: *Governor Schwarzenegger Convenes Summit on Health Care Affordability, July 24, 2006.* Available on the web at http://gov.ca.gov/index.php/press-release/2570/. Accessed 5/27/2007.

state agencies, and private partners attempting to fix long-standing barriers to care for children. That school health centers have been identified as potential partners …is a promising first step. The next step will be to examine the capacity of the state to marshal the political will as well as the technical expertise to shape a viable strategy."[19] After listening to stakeholders in five roundtable sessions regarding the role of school-based health centers under a scenario of universal coverage for all children and youth in California, we believe that the political, professional, and popular will exists for schools to play a more active role in providing access to health care to students. For a viable strategy, we recommend that the state develop and fund a program to expand access to health care in every school district based on the third option above, the school-based health access model.

V. Issues and Options for a New Model of Health Care Delivery

A. Equity

The scarce resource that limits access to health care services is not school-based health centers, but rather lack of access to insurance coverage upon which local health care services and providers are dependent. Providing health care services in low-income communities has not been commercially viable or attractive to providers because access to adequate payment for services has not been available. Universal health coverage for children and youth would radically change the landscape for providers across the state. Funding would be available to serve the tens of thousands of currently uninsured young people at any number of existing and new health care access points. Those communities wishing to support and develop school-based health centers would have increased potential for success as one of the primary barriers they have had to work against has been reimbursement for services. However, the state most likely cannot afford to develop and support a full-blown model of health care services delivery in all school districts (the start-up costs alone would be prohibitive) nor would such a model likely to be appropriate in all districts. It can, however, create and fund a basic infrastructure of services that can be available in every school district across the state to ensure equitable access to health care.

B. Schools as Access Points

A school serves a unique role as a physical location that brings together children and youth, and that connects them to information and educational services. School systems function successfully for the following key reasons:

- They provide universal access for all students to educational services;
- They provide a defined and discreet set of services;
- They deliver services according to a predetermined and predictable schedule; and
- They can make local adaptations to accommodate community needs and culture.

We submit that schools could facilitate access to health care in a similar way under reform that provides universal coverage. Since all students would have coverage, a school-based

[19] Lear, JG. Page 21.

health access program in every school district could:

- Serve as an information hub to provide access to health and enrollment information for all students;
- Provide the following set of minimum services: facilitate enrollment in health care plans, provide health prevention information, provide preventive dental health care at the elementary level, and preventive mental and behavioral health services at the middle and high school levels;
- Deliver these services to all students and their families during standard working hours at district sites; and
- Provide services in ways that are culturally competent for the community being served, and specific to the local health care environment.

VI. The School-Based Health Access Program

The School-Based Health Access Program (SBHAP) that we propose as an option for California policymakers to consider would be useful, affordable and implementable under universal coverage; it will be scalable, equitable and adaptable to the variety of schools and communities across the state; it would have an electronic backbone that would facilitate the flow of health information and data, and enable enrollment in health plans; and it would provide incentives for districts to deliver preventive dental and mental health services. Every school district would be required to provide a set of baseline services, but could also elect to augment those services with local resources to provide anything from more wellness information to full primary care services and beyond, just as 146 SBHCs across the state are doing now.

The guiding philosophy behind this model is that under universal care, all children and youth will have health coverage, and that the role of the SBHAP would be to facilitate access to health information and care from a location that is convenient, known and family-friendly. Each school district would be required to implement an SBHAP with minimum services, and be encouraged to provide additional health care services according to community interest, needs and local resources available. The California School Health Centers Association serves as a resource to communities wishing to develop SBHCs of any variety, and would be a natural ally for information and technical assistance to schools wanting to expand their SBHAP.

The SBHAP model does not presume to impede or preclude a school district's impetus to expand health care services, but rather to create a basic set of services available to all schools and all students in the Golden State regardless of location or ability to pay in order to increase access to health care under universal coverage.

Please see the appendix to this report for a chart outlining the services in the proposed SBHAP model.

Key aspects of the SBHAP are described below and include: 1) the electronic database; 2) outreach and enrollment; 3) preventive dental health; 4) preventive mental and behavioral health, 5) primary care; 6) diversity; and 7) funding.

1. Electronic Database: The success of the SBHAP would depend on a school's access to current health care data concerning its students. Under current proposals for reform, legislators have included language that would improve state electronic enrollment systems that connect children with care. As the backbone of the SBHAP, the electronic database would provide an enrollment workflow solution for school districts that would supply contact and demographic information for all students in the district, and data on health plan enrollment status and primary care physician (PCP). It could also provide essential health facts such as the student's immunization record, allergies, and medication, as well as dental, vision and behavioral health data.

As a Web-based service, the database would facilitate the refinement of health plan and physician assignment for children and youth. The service would provide secure access for the school staff person assigned to the system and allow queries on the enrollment status of the child. Descriptive attributes such as language spoken and home zip code would generate a list of appropriate plans and physicians available to the family. The school could confirm selection and changes in enrollment and PCPs.

We believe that the electronic database will be useful for several reasons, including that it will optimize a family's choice of health plan and primary care physician. This is especially important for families who have been auto-enrolled and auto-assigned. It will also be useful as a stable and transferable record of information for students who transfer schools within and between districts. When a student registers for school, their basic health information record will be available at that school, enrollment status verified, and any elective changes facilitated. Schools that seek reimbursement for services they provide will have current, accurate information to draw upon to streamline their billing processes. Finally, but not of least importance, schools will have essential health facts about each student that will increase their ability to provide appropriate care and to respond to emergencies.

2. Outreach and Enrollment: The Outreach and Enrollment function could be as simple as one school staff person accessing the electronic database to assist a family with enrollment in a health plan, changes to their primary care physician, or referral to local social and medical services as described above. However, school districts with populations of students who are newly insured under universal coverage may decide to conduct more extensive outreach to encourage access to appropriate health care services that will improve the health and readiness to learn of its students. An SBHAP would have the ability to increase the efficacy of linkages between students, pediatric providers and other child-serving entities as a key step toward improving care and services for families.

3. Preventive Dental Care: As tooth decay is a leading chronic childhood disease that, untreated, creates additional health problems and inhibits a student's readiness to learn, oral health promotion and education would be available to families through the SBHAP at all schools. In coordination with current

legislation and programs, and depending on the outcome of pending proposals, elementary schools also would provide early oral examinations and preventive treatments such as topical fluoride applications (varnishes). These services can be provided in schools and do not require a dentist or a dental chair in order to be performed.[20] School districts with SBHCs may elect to position the preventive dental health program there in coordination with the SBHAP.

The state already recognizes the importance of early oral health education and treatment to the long-term health and well-being of students. It established the school-based Children's Dental Disease Prevention Program (CDDPP) in 1979 to provide classroom oral health education, fluoride treatments, plaque control and dental sealants. Paid for with the general fund, it is a successful program serving approximately 300,000 students annually but does not enjoy a level of funding that would allow it to serve the estimated one million plus additional students who are eligible.[21] It has not been tested in the context of universal coverage, and operates as one of the interstitial services that are associated with SBHCs and school-linked health services. Our proposed strategy is based on the CDDPP concept and would integrate it into the SBHAP model with a carve-out from the Denti-Cal or Medi-Cal capitation for schools to contract with providers to perform preventive dental services. We believe that our proposal could be integrated with existing and pending legislation to dramatically increase access to vital preventive oral health services for elementary students in every school district in the state. We also believe that this initiative could inspire local efforts to expand preventive dental services to include additional school-based treatment.

4. Preventive Mental and Behavioral Health Education: Similar to our strategy for providing preventive oral health in schools, we propose that all schools make available preventive mental and behavioral health information and resources through the SBHAP, and that all middle and high schools provide preventive mental and behavioral health education programs to their students.

One of the leading health issues that affect children and youth today is the impact of violence on mental well-being. School communities are increasingly including youth development and anti-violence curricula in the classroom and in after-school programs. There are large numbers of referrals from PCPs for mental health services for adolescents and teenagers, especially from those PCPs who work with school-age populations.

The National Assembly on School-Based Health Care (NASBHC) writes that SBHCs, as collaborative partners with schools, play an important role in expanding a community's mental health services capacity and optimize the use of schools as entry

[20] "The Consequences of Untreated Dental Disease in Children" Published by The CA Society of Pediatric Dentistry and the California Dental Association. No date. Available on the web at http://www.cda.org/popup/the_consequences_of_untreated_dental_disease_in_children. Accessed 8/2/2007.

[21] The Children's Dental Disease Prevention Program: Available on the web at: http://www.dhs.ca.gov/ps/cdic/cdcb/Medicine/OralHealth/children's_dental/index.htm Accessed 8/3/2007.

points to a continuum of mental health services. Mental and behavioral health prevention and education are not reimbursable services in California, but are an essential aspect and large part of the work that SBHCs do today. In schools without SBHCs, students may not have access to similar services.[22] To remedy this gap, and to support and maintain the work that SBHCs are successfully delivering today, we propose to carve out a portion of the Medi-Cal capitation to fund school districts to deliver mental and behavioral health programs. Our recommendation stems from the belief that preventive programs result in positive outcomes for youth, especially in the areas of substance use and abuse, violence prevention (bullying, gangs), stress reduction, and life skills education.

5. Primary Care: School districts will not be required to deliver primary care services under this model. Districts that sponsor and/or host SBHCs that provide primary care will enjoy the benefit of the electronic database that should help them access health information about their students and patients more efficiently, streamline their ability to refer or provide care to students, and bill insurance for services rendered.

It is possible that universal coverage will motivate health care plans to seek out additional access points to provide health care services to enrollees. From basic preventive health education to primary care services, a plan could work together with a district to reach its young clients where they are, in schools. Universal coverage has the potential to reduce provider gaps, as providers and plans may be economically motivated to develop access points to serve community needs in new venues (such as schools) that make sense for families and youth. Universal coverage also obviates concerns about payment for services and may provide an incentive for more providers to participate in public health plans and work in historically underserved areas. Schools that can provide services and data to support improvements in Healthcare Effectiveness Data and Information Set (HEDIS) performance measures may be particularly attractive to health plans.

6. Diversity of the SBHAP Model or "100 Flowers Blooming": Under the School-Based Health Access Program, each community will have the choice to build upon the SBHAP model to whatever degree it deems appropriate according to its interests and needs.

An expanded model of the SBHAP program under universal coverage could increase a school's ability to address barriers to health care that often exist for low-income and/or underserved students such as transportation, fear of and lack of familiarity with health care systems, language, location and convenience. The cultural competency of schools, in conjunction with potential marketplace incentives for health plans under universal coverage, will likely combine to make primary care in schools more desirable for health providers and plans.

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[22] National Assembly of School-Based Health Centers: "Why mental health in school-based health centers?" Available on the web at: http://www.nasbhc.org/site/c.jsJPKWPFJrH/b.2642293/k.85AC/mental_health.htm Accessed 8/2/07.

As the California affiliate of the National Assembly of School-Based Health Centers (NASBHC), The California School Health Centers Association (CSHC) CSHC supports the efforts of schools across the state to expand access to health care treatment and education for their students. It was incorporated in 1995 "… to promote the health and academic success of children and youth by increasing access to the high quality health care and support services provided by school health centers. CSHC pursues this mission by advocating for public policies that support school health centers; building support among policymakers, community leaders, parents and students; and providing technical support to new and existing school health centers."[23] A school district or community seeking to expand upon its SBHAP could find technical assistance and other resources to support and develop a locally appropriate solution to its need through the CSHC.

7. Funding: The funding for a School-Based Health Access Program would come primarily from the same sources of funds that SBHCs access today: state health insurance programs, third-party payers, and local grants. Our proposal recommends consideration of the following three significant changes to the way funding would be delivered:

1. The state would pay for the development and implementation of the electronic database required for all school districts and assures the availability of the infrastructure to allow outreach and enrollment to take place within schools.
2. The state would create a Denti-Cal or Medi-Cal carve-out for school districts to provide preventive oral health care to elementary school students.
3. The state would create a Medi-Cal carve-out for school districts to provide preventive mental and behavioral health education to middle and high school students.

The state would fund the development, implementation and maintenance of the electronic database system. The database provider would develop and deliver training to school personnel, and provide technical assistance for start-up to all school districts. Additionally, the state would assure the availability of the infrastructure necessary for outreach and enrollment to occur in schools. Every school district would be required to provide computer access and Web connectivity to the electronic database, and provide staff for training and to access and implement the system.

A carve-out from Denti-Cal or Medi-Cal for school districts would be the primary funding stream for elementary schools to provide preventive oral health care to students. Funding would be based on incentives for schools to provide care, and services could be provided directly by licensed and authorized school personnel or contracted dental health providers.

Preventive mental and behavioral health education would be funded similarly to oral health services through a Medi-Cal carve-out for schools. As much of the preventive mental and behavioral health educational services

[23] www.schoolhealthcenters.org

that are performed by SBHCs today are not reimbursable through insurance coverage, this funding mechanism would ensure that schools are able to provide services significant and integral to adolescent and teen wellness. Individual counseling and other mental and behavioral health care treatment services would continue to be funded through Medi-Cal, Healthy Families, and third-party payers.

Please see the appendix of this report for a chart that outlines the potential services and funding streams for our SBHAP model.

VII. The Governor's Advisory Workgroup on School-Based Health Centers

The Governor's Advisory Workgroup on School-Based Health Centers responded to its charge with a list of recommendations regarding support for SBHCs in elementary schools under universal care. Our study looked at the potential roles of schools and/or school-based health centers and their many public and private partners across the state under universal care. These two studies are different but complementary. The strategies suggested by the Workgroup do not conflict with the recommendations of this report, but generally have a different focus. Additionally, several of the recommendations of the Workgroup are particularly salient to the model for the SBHAP that we are proposing.[24] Specifically, the Workgroup recommends:

- (#3) "…that the California Health and Human Services Agency, in collaboration with the California Department of Education, establish program standards … defining a minimum level of service that addresses medical, dental, vision, and mental health education, screening and assessment, and referral and other prevention and health promotion activities."

  This is very similar to the set of minimum mandated services in the SBHAP model.

- (#4) "…that the California Health and Human Services Agency explore how non-clinical prevention and wellness services provided by SBHCs and other school health providers can be funded in keeping with the goals of the Governor's Health Care Reform Proposal."

  This is similar to our proposal that would establish a preventive mental and behavioral health carve-out incentive for school districts to provide these services in all middle and high schools, and optionally in elementary schools.

- (#5) "…that the California Health and Human Services Agency assist SBHCs in 1) participating in electronic enrollment gateways for the purpose of ensuring that children enroll and retain health coverage in the most efficient manner possible, and 2) exchanging health information electronically for the purposes of improving access to coordinated care and reducing duplication, while ensuring individual and family privacy."

[24] For a complete list of recommendations, please see page iii: Governor's Advisory Workgroup on School-Based Health Centers: Executive Summary and Full Report and Recommendations.

This is similar to our proposal that would place an electronic health information system in every school district.

Stakeholders who participated in either or both of these studies raised important issues concerning health care for children and youth that may be addressed by proposed reform legislation.

VIII. Concluding Remarks

It is possible that the Governor's office might come under fire if this streamlined model for a school-based health access program is implemented, as some stakeholders will prefer funding for full-service school-based health centers. We believe that these criticisms would be misplaced. The efforts of policymakers should be focused on assuring that every school district works with local public health systems and public and private insurers to develop plans for community-specific health care delivery that makes use of schools as hubs for information, outreach and enrollment in health plans, and to provide access to basic wellness education and some preventive services. Additional health care services should be available at schools or through school-linked services according to the specific needs of the local population and the resources available in or generated by the community through stakeholder groups. Separate state funding for a school-based health center grant program may meet the needs of some communities. Without readily available access to health information and basic preventive services in all schools, there will be little or no change to the status quo in most communities and for most of California's children and youth. A school-based health access program will assure that universal coverage achieves its purpose of increasing widespread access to health care services for all children and youth.

VX. Next Steps

This project was designed to present issues and options for further study. Given the legislative calendar, if some of these issues and options resonate with policymakers, we would recommend the following topics for further investigation:

1. The exploration and definition of issues involved in implementing a School-Based Health Access Program model.
2. The potential integration and alignment of the School-Based Health Access Program model with current and pending legislation in these and other areas: oral health screening, treatment and education; school health centers; the Mental Health Services Act; and outreach and enrollment.
3. The exploration of whether there is an opportunity to reframe the ways that services are delivered to children and youth with special needs under the scenario of universal coverage.

Appendix

Chart: The School-Based Health Access Model: Services and Funding Streams

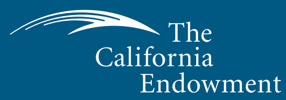
List of Roundtable Participants

THE CALIFORNIA SCHOOL-BASED HEALTH ACCESS PROGRAM				
	Mandated Baseline Services	**Funding Stream**	**Optional Sevices**	**Funding Stream**
Outreach & Enrollment	• Enrollment in health plans and PCP selection • Preventive health education	• State funding for electronic database and infrastructure • State assurance of availability of the infrastructure to conduct services		
Primary Care	• Not required		• Small NP clinic to comprehensive clinic for any or all school levels	• Local grants • Third-party payers
Dental Health	• Elementary Preventive Care	• Incentive for # served may be carved out of the Denti-Cal or Medi-Cal capitation • May require changes in scope of practice • Will require coordination with current legislation for K-1 oral health exams CDDPP	• Additional dental care services for any or all school levels	• Local grants • Third-party payers
Mental Health	• Middle and high school level preventive mental and behavioral health education	• Funding may be carved out of the Medi-Cal capitation	• Elementary preventive mental and behavioral health education • Comprehensive mental health services at any or all school levels	• Local grants • Third-party payers

Participants in Roundtable Sessions

Phinney	Ahn	LA Care
Robert	Baldo	ARCA (Regional Centers Group)
Roberta	Bavin, PNP	Sierra Vista-Clovis Unified School District
Michael	Baxter	San Francisco Department of Public Health
Catherine	Blakemore	Protection and Advocacy (PAI)
Stacey	Blankenbaker	San Francisco Unified School District
Charity	Bracy, MS	California Children's Hospital Association
Kerry	Brown	Blue Cross of California
Michelle	Burns	Alameda County Behavioral Health Care Services
Kris	Calvin	American Academy of Pediatrics – CA
Becky	Cannon	Pathways Counseling
Paulette	Carpenter	Tulare Community Health Clinic, Inc.
Cara	Chastain, MBA	CalOptima
Elisabeth	Chicoine	Roseland Children's Health Center
Serena	Clayton, PhD	California School Health Centers Association
Joel	Cohen	The Dental Health Foundation
Kristin	Curran, MPP	California School Health Centers Association
John	DiCecco	Los Angeles Unified School District
Diana	Dooley	California Children's Hospital Association
Patrick	Gardner	National Center on Youth Law
Ross	Gentry	Tulare Joint Union High School District
Sandi	Goldstein	Adolescent Health Collaborative
Cathy	Grant	Blue Cross
Merry	Grasska, NP	Costa Mesa-Newport Unified School District
Wynne	Grossman	The Dental Health Foundation
Riva	Guimond	Exceptional Parents Unlimited
Lisa	Guthrie	Health Net of California
Maricella	Gutierrez	Tiburcio Vásquez Health Center, Inc.
Bonnie	Hamilton, MD	Kaiser Permanente Council on Legislation, California Medical Association
Candice	Hilvers, MSN, PNP	Tulare County Office of Education
Steven	Holdridge	Tech Prep High School
Sandra	Jones	Jordan High School Health Center
Michael	Klein	Fight Crime, Invest in Kids California
Tamar	Kurlaender, MPH	Alameda Family Services SBHC, California School Health Centers Association
Hector	Lara	California School Health Centers Association
Yvette	Leung, MPH	Alameda County School Based Health Center Coalition

Sandra	Lewis	Western Health Advantage
Jan	Marquard	Northeast Valley Health Corporation
Chris	Ohman	California Association of Health Plans
Dale	Parent, RN, BSN, EdD	CA School Nurses Association Chula Vista Elementary School District
Su	Park	Children's Hospital Oakland
Sharon	Phillips, MSN, SNP	Tulare County Office of Education
Jenn	Rader	El Cerrito High School
Erin	Riggs	California Mental Health Directors Association
Jesus	Sanchez	Blue Cross State Sponsored Business
Steve	Scheibel, MD	COCHS
Rusty	Selix	Mental Health Association in California
Judy	Silva, RN	Tulare Community Health Clinic, Inc.
Vergia	Slade, MHA	Health Net of California
Donna	Slimak	Santa Barbara Regional Health Authority
Kathy	Smith	USC University Center of Excellence in Developmental Disabilities at Children's Hospital Los Angeles
Tim	Smith	LA Care
Michael	Smith	California School Health Centers Association
Nancy	Spradling	California School Nurses Organization
Barbara	Staggers, MD	Children's Hospital Oakland
Lisa	Sterner	Berkeley High School Health Center
Ahna	Suleiman	Contra Costa County Health Services
Linda	Swan	Family Voices of California
Howard	Taras, MD	UCSD Medical Group UCSD School of Medicine
Catherine	Teare	Consultant
Zooey	Todd	California Department of Mental Health
Sang Leng	Trieu	California School Health Centers Association
Bonnie	Trinclisti, RN, FNP	Alameda Family Services, Tri-High School Health Centers
Kim	Uyeda	Los Angeles Unified School District
Karen	Vicari	Mental Health Association in California
Renee	Wachtel, MD	Children's Hospital Oakland and AAP Committee member
Pam	Wagner	Los Angeles Trust for Children's Health
Andrew	Whitelock	Molina Health Care
Susan	Yee	Roosevelt Middle Health Center and Oakland High School Health Center



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